Complete Summary

GUIDELINE TITLE

Evidence-based practice guideline. Detection and assessment of late life anxiety.

BIBLIOGRAPHIC SOURCE(S)

Smith M, Ingram T, Brighton V. Evidence-based practice guideline. Detection and assessment of late life anxiety. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2008 Nov. 51 p. [112 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Late life anxiety, including anxiety disorders, clinically significant anxiety, phobias, and depression

Note: Anxiety is often defined as the combination of apprehensive expectation (the vague feeling that something bad is about to happen), and worries that are both unrealistic and excessive.

GUIDELINE CATEGORY

Evaluation
Risk Assessment
Screening

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Occupational Therapists
Physical Therapists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

To provide an evidence-based guideline to improve the detection and assessment of anxiety symptoms among older adults

TARGET POPULATION

Older adults at risk for late life anxiety that are receiving health-related services

INTERVENTIONS AND PRACTICES CONSIDERED

1. Risk assessment
2. Assessment of anxiety with tools and forms, such as:
    - The *Geriatric Anxiety Inventory* (GAI)
    - The *Short Anxiety Screening Test* (SAST)
    - The *Hospital Anxiety and Depression Scale* (HADS)
    - *Rating Anxiety in Dementia* (RAID)
    - *Mini-Mental State Exam* (MMSE)
3. Diagnostic assessment of anxiety by qualified health or mental health provider if anxiety is detected
4. Monitor anxiety signs and symptoms

MAJOR OUTCOMES CONSIDERED

- Quality of life and overall health
- Physical and social function
- Timely identification of symptomatic older adults with risk factors

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The initial literature search was conducted electronically and included use of MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsychINFO, and the All EMB Reviews databases. The All Evidence Based Medicine (EMB) database includes Cochrane's Controlled Clinical Trials Registry (CCTR) and Database of Systematic Reviews (DSR), the Database of Abstracts of Review of Effects (DARE), and APC Journal Club.

A variety of keywords and limits were employed, using the unique limits offered in each of these databases to target research about the assessment of anxiety disorders in late life. Attempts to search using the key words "anxiety assessment" and "anxiety disorders assessment," or "assessment" combined with "Anxiety Disorders," were not productive in identifying relevant literature. Instead, searches were conducting using Anxiety Disorders, and a variety of limits such as Diagnosis, Epidemiology, and Evaluation, to narrow the review to articles that potentially dealt with assessment methods. Refer to Table 1 of Appendix E n the original guideline document to review databases, search strategies used and results.

For example, in the MEDLINE search (1999 to 2005 database), a focused search using key words "Anxiety Disorders" was first limited to "Diagnosis" resulting in 472 articles, and then to articles in English and "all aged 65 and older," resulting in 88 articles that were then further screened according to content in titles and abstracts. Additional MEDLINE search strategies included an unfocused search using "Anxiety Disorders/Diagnosis" (n = 1409 articles), then limiting that search to English and over age 65 years, and to "clinical trial" (n = 26) and "evaluation studies" (n = 6).

Similar strategies were employed with the CINAHL database. Both focused and unfocused searches using keywords Anxiety Disorders/Diagnosis were used, resulting in 44 and 116 articles respectively. Each was then limited to articles in English, classified as research, and related to older adults ("aged 65 to 79" and "80 years and older"), resulting in 3 and 8 articles.

Review of literature identified was undertaken, using the following criteria for evaluation. First, studies that did not include a majority of older adults in the sample were excluded. Of note, many articles list "aged" as a search term because the sample includes adults, some of whom may be over 60 years of age. However, in the vast majority of these, older adults are a small minority of the sample, and thus were excluded.

Second, structured and semi-structured interview schedules that are commonly used in epidemiological studies were not reviewed. Instead, the literature review centered on self report and clinician rated scales that may be used in clinical

practice to assess anxiety. A two step process in the search was employed once an anxiety scale was identified. First, references that described the scale's development or validation with older adults were explored to assure that earlier literature related to the scale (or other scales) was included. Second, an electronic search using the scale name was undertaken to identify additional literature that described its use and/or validation with older adults.

Follow-up Literature Search

Literature reviewed initially identified several scales that were either specifically developed for use with older adults or have been validated for use with elderly populations. To further examine possible literature related to these scales in late life, a second search was initiated using the scale name as the search term. Two searches, one in Medline and the other in PsychInfo were conducted in this manner. Each was then followed by limiting the search to publications in English and among individuals aged 65 years and older. This approach resulted in a small number of additional articles, and also validated the importance of articles identified in the earlier search.

Two additional literature searches were conducted. Search terms and methods described above were conducted for publication dates of June 2006 through June 2007. The search was narrowed to 90 articles that were reviewed for relevance to the project topic and meeting age criteria. Twelve articles were critiqued further for inclusion, and 3 were included in the review. Search methods described above repeated again in August 2008 for publication dates of July 2007 through July 2008. The search was narrowed to 36 articles that were reviewed for relevance to the project topic and meeting age criteria. Ten articles were critiqued further for inclusion and 5 were included in the review.

NUMBER OF SOURCE DOCUMENTS

See table titled "Literature Search Strategies and Outcomes" in Appendix E of the original guideline document.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The grading scheme used to make recommendations is as follows:

A1: Evidence from well-designed meta-analysis or well-done systematic review with results that consistently support a specific action (e.g., assessment, intervention, or treatment)

A2: Evidence form one or more randomized controlled trials with consistent results

B1: Evidence from high quality evidence-based practice guidelines

B2: Evidence from one or more quasi experimental studies with consistent results

C1: Evidence from observational studies with consistent results (e.g., correlational, descriptive studies)

C2: Inconsistent evidence from observational studies or controlled trials

D: Evidence from expert opinion, multiple case reports, or national consensus reports

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Research findings and other evidence, such as guidelines and standards from professional organizations, case reports and expert opinion were critiqued, analyzed and used as supporting evidence.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This guideline was developed from a systematic review and synthesis of current evidence on detection of anxiety in older adults with dementia.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (*A1, A2, B1, B2, C1, C2, D*) are defined at the end of the "Major Recommendations" field.

Definition of Anxiety Symptoms

Diverse psychological, physical and behavioral symptoms are associated with anxiety in late life. Anxiety is often defined as the combination of apprehensive expectation, (the vague but nagging feeling that something bad is about to happen), and worries that are both unrealistic and excessive. Additional anxiety-related symptoms include irritability, uncertainty, fearfulness, unrealistic fears, rumination (e.g., preoccupation with repetitive negative thoughts), impaired concentration, restlessness, fidgeting, and repetitive behaviors. Autonomic nervous system arousal associated with anxiety may contribute to physical symptoms, including cardiac (e.g., heart beating out of the chest), respiratory (e.g., shortness of breath), gastrointestinal (e.g., butterflies in stomach, diarrhea), musculoskeletal (e.g., physical tension, headache) and other health-related signs and symptoms (American Psychiatric Association [APA], 2000). Common general symptoms of anxiety in late life are listed in Table 1 of the original guideline document.

Individuals/Patients at Risk for Late Life Anxiety

Two primary groups of risk factors must be considered to promote the optimal detection and assessment of late life anxiety:

- Factors that reduce the likelihood that anxiety will be recognized *as anxiety*—by the older person him/herself, family members, and the health care team
- Factors that increase the risk that anxiety will occur

Factors That Reduce the Likelihood That Anxiety Is Recognized

Attitudes and beliefs that influence the assessment of older adults with anxiety include the following points (Beck & Averill, 2004; Beck & Stanley, 2001; Beyer, 2004; Carmin, Wiegartz, & Scher, 2000; Dada, Sethi, & Grossberg, 2001; Flint, 1994; Fuentes & Cox, 1997; Gorman, 2001; Kogan, Edelstein, & McKee, 2000; Lenze, et al., 2001. Evidence Grade = C1).

- ***Stigma*** associated with mental illness, such as fear of being labeled as "crazy" and being shunned, continue to interfere with help-seeking behaviors for mental disorders among older adults.
- ***Interpretation of psychological symptoms as physical ailments*** increases the risk that symptoms are attributed to medical causes or being a hypochondriac. Of equal importance, physical symptoms, such as pain, headaches, nausea, heartburn, and diarrhea are significantly associated with anxiety (Haug, Mykletun, & Dahl, 2004. Evidence Grade = C1).
- ***Under-reporting and denying problems***, including anxiety symptoms that are observed and reported by family members and saying anxiety does not

exist in a family member who self-reports anxiety, is common among older adults (Levy, et al., 2003. Evidence Grade = C1).

- ***Labels used for anxiety***, such as denying anxiety but complaining of feeling nervous, fretful, worked up, or worried about their physical health or safety, may contribute to under-estimation of problems and misunderstandings.
- ***Ageist attitudes and beliefs***, like the mistaken belief that anxiety and depression are "natural reactions" to aging, reduce the likelihood that problems are identified and treated. For example, anxiety may be regarded as an understandable reaction to life stress and, as a result, not be fully assessed or treated.
- ***Diagnostic difficulties***, such as distinguishing "unrealistic" and "excessive" worry from worry that is grounded in real-life fear associated with recent experiences (e.g., fear of victimization, injury, falling), often challenge older adults and clinicians alike.
- ***Setting-specific deficits***, particularly in primary care where most older adults seek help for their psychological problems, may contribute to problems. For example, unrecognized and untreated anxiety and depression are both common in primary care settings (Bartels, et al., 2004; Bogner, et al., 2005; Cole, Bellavance, & Mansour, 1999; Colenda, et al., 2003; Edlund, Unutzer, & Wells, 2004; Harman, et al., 2002; Katon & Roy-Byrne, 2007; Wilheim, et al., 2008; Kroenke, et al., 2007; Lecrubier, 2007. Evidence Grade = C1).
- ***Somatic complaints***, such as pain and physical distress for which there is no identifiable cause, may represent psychological problems among older adults (Beekman, et al., 1998; Carmin, Wiegartz, & Scher, 2000; de Waal, et al., 2004; Dugue & Neugroschl, 2002; Flint & Rifat, "Relationship," 2002; Sable & Jeste, 2001. Evidence Grade = C1).

Factors That Increase the Likelihood That Anxiety Will Occur

Factors that are consistently associated with increased risk of clinically significant anxiety in late life, including anxiety disorders, include the following:

- ***Physical Illness***, including those listed in Table 2 in the original guideline document (Astrom, 1996; Beekman, et al., 1998; Beyer, 2004; Carroll, et al., 1993; Cohen, et al., 2006; Hocking & Koenig, 1995; Kvaal, et al., 2001; Levy et al., 2007; Smith, et al., 2002. Evidence Grade = C1).
- ***Psychosocial Stress***, including death or illness of family members, traumatic events such as falling or being victimized (Beekman et al., 1998; De Beurs, et al., 2000; Gagnon, et al., 2005; Palmer, Jeste, & Sheikh, 1997. Evidence Grade = C1).
- ***Depression***, including undiagnosed depression (Alexopoulos, 1990; Andreescu, et al., 2007; Cohen, et al., 2006; Flint & Rifat, 1997, 2002a; Kirby, et al., 1999; Kroenke, et al., 2007; Lenze, et al., 2000; Lenze, et al., 2001; Steffens & McQuoid, 2005; Stordal, et al., 2003. Evidence Grade = C1).
- ***Cognitive Impairment***, including both dementia and mild cognitive impairment (Ballard, et al., 1996; Eustace, et al., 2002; Fossa & Dahl, 2002; Geda, et al., 2004; Haupt, Kurz, & Janner, 2000; Hwang, et al., 2004; Lyketsos, et al., 2002; Mega, et al., 1996; Ownby, et al., 2000; Sinoff & Werner, 2003; Teri, et al., 1999. Evidence Grade = C1).

- ***Personal Characteristics*** that are associated with anxiety should be considered together with other risk factors, including:
    - Female gender (Beekman, et al., 1998; Blazer, et al., 1991; De Beurs, et al., 2000; Heun, Papassotiropoulos, & Ptok, 2000; Regier, et al., 1998. Evidence Grade = C1).
    - Advanced age (Christensen, et al., 1999; Cohen, et al., 2006; Evidence Grade = C1).
    - Lower educational or professional levels (Beekman, et al., 1998; Cohen, et al., 2006; Heun, Papassotiropoulos, & Ptok, 2000; Evidence Grade = C1).
    - External locus of control (Beekman, et al., 1998; Powers, Wisocki, & Whitbourne, 1992. Evidence Grade = C1).
    - Family history of anxiety disorder (Beekman, et al., 1998; Hettema, Neale, & Kendler, 2001. Evidence Grade = C1).
    - Evidence of alcohol or drug use (Beekman, et al., 1998; Cohen, et al., 2006; Grant, et al., 2004; Mohlman, et al., 2004. Evidence Grade = C1).
    - Latino ethnicity (Diefenbach, et al., 2004; Lewis-Fernandez et al., 2002; Tolin, et al., 2005. Evidence Grade = C1).

Assessment Criteria

Any person aged 60 years and older who expresses worry or fear, and who is identified as being at risk according to the factors listed in the section above (e.g., physically ill, recent psychosocial stress, depressed, cognitively impaired, somatic complaints for which there are no identifiable causes), should be evaluated for anxiety. Common sources of worry and fear among older adults are noted in Table 3 below.

Table 3: Worries and Fears in Older Adults*

Being unable to remember important things; mental decline	Being physically disabled
Inability to care for oneself	Falling
Losing eyesight or hearing	Losing control of bodily functions
Spouse/family becoming ill, having an accident	Losing sight or hearing
Being forced to live in a nursing home	Being robbed or attacked
Loss of ability to get around by oneself	Death of family/friends
Dependence on health care providers	House being burgled/vandalized
Being taken care of by strangers	Feeling insecure
Being a burden for loved ones	Getting older
Becoming ill/having an accident	Dying

* These worries and fears were commonly expressed by older adults, but not by younger ones, in research comparing the content of worries in younger and older people.

Sources: Diefenbach, Stanley, & Beck, 2001; Kogan & Edelstein, 2004; Ladouceur et al., 2002; Wisocki, 1988. Evidence Grade = C1.

Differentiating anxiety that is unrealistic, excessive, and life-altering from usual worry is often difficult in older adults. The type of worries and fears expressed by older adults are different than the worries and fears of younger people. For example, older adults are more likely to express worry about health and illness compared to younger people (Diefenbach, Stanley, & Beck, 2001; Kogan, Edelstein, & McKee, 2000; Ladouceur, et al., 2002; Wisocki, 1988. Evidence Grade = C1).

Given that older people worry about realistic problems—such as falling, losing hearing or eyesight, and becoming dependent on others—considerable effort is often needed to determine if the extent of worry interferes with daily function (Beck & Stanley, 2001; Flint, 2001. Evidence Grade = C1). Additional evidence suggests that meta-worry, which is worry about one's own thoughts or worrying about worrying, significantly predicts the degree of interference of worry in daily life for older adults (Nuevo, Montorio, & Borkovec, 2004. Evidence Grade = C1).

The overlap between physical health problems in late life and anxiety is another important area to consider. Anxiety is observed to interact with physical illness in several important ways (Beyer, 2004; Flint, 2001; Sable & Jeste, 2001; Sheikh, 1991. Evidence Grade = D):

- Physical illness can directly cause anxiety related symptoms.
- Physical illness can trigger a reaction of anxiety, worry and/or fear.
- Somatic (physical) symptoms of anxiety are often the focus of older adults' complaints.
- Medications used to treat physical illness may cause anxiety-related symptoms.
- Circular problems, in which increased anxiety results in behaviors that contribute to worsening of physical health conditions, are common.

Thorough review of physical health conditions and their treatment are often essential to differentiating the source of anxiety-related symptoms, particularly when physical symptoms are the focus of complaints (e.g., sleep disturbance, headache, fatigue, palpitations).

Assessment Tools and Forms

There are many different types of anxiety assessment scales. Because this guideline focuses on general anxiety detection (not diagnosis or detection of change related to treatment), four scales that are designed for screening anxiety are included in Appendix A in the original guideline document, including:

- The *Geriatric Anxiety Inventory* (GAI), a 20-item self-report measure that is scored yes and no (Pachana, et al., 2007). See Appendix A.1 in the original guideline document.
- The *Short Anxiety Screening Test* (SAST), a 10-item scale that is rated on a 4-point scale and that may be clinician scored based on interview, or may be used as a self-report measure (Sinoff, et al., 1999; Sinoff & Werner, 2003). See Appendix A.2 in the original guideline document.

- The *Hospital Anxiety and Depression Scale* (HADS) includes 7 items each for anxiety and depression that are self-rated using a 4-point scale, and excludes physical symptoms to help distinguish anxiety and depression from medical problems (Spinhoven, et al., 1997; Wetherell et al., 2007; Zigmond & Snaith, 1983). See Appendix A.3 in the original guideline document.
- *Rating Anxiety in Dementia* (RAID) that includes 20 items that are rated on a 3-point scale using a combination of direct observation and interview, and the report of a person who knows the older person well, and is appropriate for use with persons who are cognitively impaired (Shankar, et al., 1999). See Appendix A.4 in the original guideline document.
- *Mini-Mental State Exam* (MMSE) may be used to assess the person's cognitive function if questions arise about the reliability of his/her self report of feelings, sensations, and experiences (Folstein, Folstein, & McHugh, 1975). See Appendix A.5 in the original guideline document.

Each scale was designed to be used as a screening instrument to help clinicians identify the presence of anxiety. The SAST and HADS also assess the older person's perception of the severity of the symptoms. The RAID may be used if the person appears to have cognitive impairments that might interfere with his/her accurate report of symptoms. In this case, the MMSE (Folstein, Folstein, & McHugh, 1975) may be used to assess level of cognitive impairment. Based on this information, additional physical and mental health-related assessment may be undertaken to differentiate anxiety from other problems, and institute appropriate therapies.

Description of the Practice

The scales recommended in this guideline are designed to screen for anxiety, not make clinical diagnoses. Detection of clinically significant anxiety should trigger a diagnostic assessment by a qualified health or mental health provider, preferably one with expertise in geriatric psychiatry.

The anxiety scales included are guided by specific instructions that are individualized to the scale. Important points to remember when using any of these scales are:

- Explain why you are asking these questions, emphasizing the important relationship between physical and emotional health.
- Explain that there are no right or wrong answers.
- Encourage the older adult to choose the answer that is closest to how they have been feeling recently (in the past week).
- Provide sufficient time to complete the scale without the client feeling hurried.
- Provide a private area where others may not easily see responses.

The following steps are recommended:

1. If cognitive impairment is suspected (which may interfere with accurate self report), use the Mini-Mental State Exam (MMSE) to assess level of function (Folstein, Folstein, & McHugh, 1975). See Appendix A.5 in the original guideline document.
    a. If the person scores below 24 of 30 points (≤23) on the MMSE, the Rating Anxiety in Dementia (RAID) scale may be more suitable for

assessing anxiety symptoms. See Appendix A.4 in the original guideline document.

b. If the person scores 24 or above on the MMSE (≥24), administer the Short Anxiety Screening Test (SAST). See Appendix A.2 in the original guideline document.

2. The SAST may be self-administered or clinician-scored based on interview. Persons scoring 22 or above (≥ 22) on the 40 point scale should be referred for further evaluation of the person's increased risk for anxiety. See Appendix A.2 in the original guideline document.
3. If the person has difficulty using the SAST (which is scored on a 4-point scale), substitute the Geriatric Anxiety Inventory (GAI). The GAI includes 20 statements that are scored "yes" or "no". Individuals with a score of 8 or greater (≥8) should be referred for further evaluation. See Appendix A.1 in the original guideline document.
4. If the person presents with both anxious and depressed symptoms, administer the Hospital Anxiety and Depression Scale (HADS). The HADS is self-administered and results in subscale scores for anxiety and depression. A score of 8 or greater (≥8) on either subscale should trigger further evaluation. See Appendix A.3 in the original guideline document.
5. If the person scores below 22 (< 22) on the SAST, 8 on the GAI (< 8) , or 8 on either subscale of the HADS, continue to monitor anxiety-related symptoms, including those related to:
    - *Mood disturbance*, including visible signs (e.g., grimacing, worried facial expression or vocal inflection, sighing, jitteriness) and symptoms expressed as worries, fears, apprehensions, ruminations.
    - *Behaviors*, including restlessness, fidgeting, repetitive behaviors (e.g., rubbing, twisting hair, questions/comments), irritability, pacing, vigilance.
    - *Physical symptoms*, including diaphoresis, dizziness, dry mouth, dyspnea, flushing, insomnia (getting to sleep, staying asleep, early awakening), headaches, palpitations, or trembling.
    - Refer again to Table 1 in the original guideline document to review common late life anxiety signs and symptoms.
6. Remember that subthreshold anxiety (anxiety that does not meet criteria for being an anxiety disorder) is often clinically significant, causing distress, discomfort, and disability that interferes with quality of life.
7. Monitor the severity and persistence of anxiety signs and symptoms—at least weekly, if not more often—to assure that steps are taken to rule in/out other causes of distress.

Definitions:

The grading scheme used to make recommendations is as follows:

A1: Evidence from well-designed meta-analysis or well-done systematic review with results that consistently support a specific action (e.g., assessment, intervention, or treatment)

A2: Evidence from one or more randomized controlled trials with consistent results

B1: Evidence from high quality evidence-based practice guidelines

B2: Evidence from one or more quasi experimental studies with consistent results

C1: Evidence from observational studies with consistent results (e.g., correlational, descriptive studies)

C2: Inconsistent evidence from observational studies or controlled trials

D: Evidence from expert opinion, multiple case reports, or national consensus reports

CLINICAL ALGORITHM(S)

A clinical algorithm is provided in the original guideline document for the detection and assessment of late life anxiety.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Use of this guideline will result in improved detection of clinically significant anxiety among older adults.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This is a general evidence-based practice guideline. Patient care continues to require individualization based on patient needs and requests.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Process Indicators

Process Indicators are those interpersonal and environmental factors that can facilitate the use of a guideline.

One process factor that can be assessed with health care providers and other caregivers is knowledge about anxiety symptoms in late life. The **Late Life Anxiety Knowledge Assessment Test** (see Appendix B in the original guideline document) should be assessed before and following education about use of this guideline.

The same sample of health care providers and caregivers for whom the Knowledge Assessment test was given should also be given the **Process Evaluation Monitor** (see Appendix C in the original guideline document) approximately one month following his/her use of the guideline. The purpose of this monitor is to determine his/her understanding of the guideline and to assess the support for carrying out the guideline.

Outcome Indicators

Outcome indicators are those expected to change or improve from consistent use of the guideline. Use of this guideline will result in improved detection of clinically significant anxiety among older adults. The major outcome indicators that should be monitored over time are:

- **Primary Outcome**: Identification of symptomatic older adults who have risk factors for clinically significant anxiety and who may benefit from timely detection and treatment of distressing symptoms.
- **Secondary Outcomes**: Improved quality of life, overall health, and functional status; more effective use of health resources.

The Late Life Anxiety Assessment monitor described in Appendix D in the original guideline document is to be used for monitoring and evaluating the usefulness of the Detection and Assessment of Late Life Anxiety guideline in improving outcomes of patients who experience significant risk factors for the development of clinically significant anxiety symptoms. **Please adapt this outcome monitor to your organization or unit and add outcomes you believe are important**.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm
Quick Reference Guides/Physician Guides
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Smith M, Ingram T, Brighton V. Evidence-based practice guideline. Detection and assessment of late life anxiety. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2008 Nov. 51 p. [112 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Nov

GUIDELINE DEVELOPER(S)

University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core - Academic Institution

SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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Series Editor: Marita G. Titler, PhD, RN, FAAN

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available on CD upon request.

Print copies: Available from the John A. Hartford Foundation's Center of Geriatric Nursing Excellence at the University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core, 4118 Westlawn, Iowa City, IA 52242. For more information, please see the University of Iowa Gerontological Nursing Interventions Research Center Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Detection and assessment of anxiety in late life. Quick reference guide. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2008 Nov. 2 p.

Print copies: Available from the John A. Hartford Foundation's Center of Geriatric Nursing Excellence at the University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core, 4118 Westlawn, Iowa City, IA 52242. For more information, please see the University of Iowa Gerontological Nursing Interventions Research Center Web site.

The original guideline document and its appendices include a variety of implementation tools, including outcome and process indicators, staff competency materials, and other forms.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI Institute on August 10, 2009. The information was verified by the guideline developer on September 9, 2009.

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